

## DSHS | Children's Mental Health Initiative

Coordinating Care and Improving Mental Health Outcomes for Children and Youth



### STRATEGY 1 | Introducing and Expanding Use of Evidence Based Practices (EBPs)

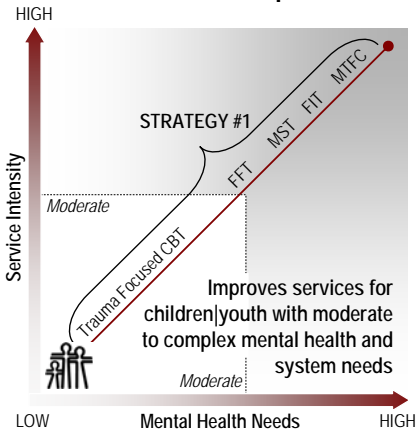
#### Goal: Achieve Better Outcomes for Kids and Families

Children and youth with mental health needs are served by many programs operated or funded by DSHS. Many mental health practices, including therapy interventions, have been studied nationally and in our state to determine how effectively they impact the lives of children, youth, and families. Effective practices result in improved mental health and better functioning at home and school; increased likelihood of staying at home or being in a stable placement; and reduced levels of juvenile crime. DSHS wants more children, youth, and families to have the opportunity to receive therapies that have been proven to be effective and that will better serve youth with multiple complex needs. Thus, DSHS has created the Children's Mental Health Initiative (CMHI) to coordinate delivery across three DSHS programs – Mental Health, Children's (child welfare), and Juvenile Rehabilitation. This handout summarizes the plan for Strategy 1: Implementing Evidence Based Practices (EBPs).



#### Effective Therapy Interventions for Kids and Families

##### With moderate to complex needs



CMHI Strategy 1 expands and jointly administers a set of Evidence Based Practices. These research-based practices improve child, youth and family functioning, increase stability of care, decrease crisis-driven out-of-home placement, and reduce crime.

##### Strategy 1 establishes:

- A consistent set of EBPs that will improve outcomes common to all three administrations.
- Common quality assurance, adherence, training, monitoring and evaluation protocols
- Incentives to support use of these EBPs across all three administrations, for both shared clients and for children seen only in one administration.

#### Evidenced Based Practice Selection Criteria

##### Does the Evidenced Based Practice?

Yes No

- ☒ ☐ Address common diagnoses (conduct, mood, anxiety, PTSD, and ADHD).
- ☒ ☐ Improve common system outcomes (reduces out-of-home placement, care crises, instability and arrests).
- ☒ ☐ Come well packaged and robust.
- ☒ ☐ Apply cross-culturally.
- ☒ ☐ Fit into the continuum of care.

##### Strategy 1 EBP process:

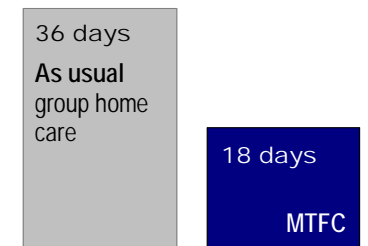
- **Fall 2004:** Expert Panel recommended set of EBPs for CMHI to consider.
- **Winter 2005:** Staff workgroup recommended five EBPs for initial implementation. In some cases, existing examples of EBPs will be expanded; in other cases, new EBPs will be added.
- **Spring 2005:** Planning and feedback on the CMHI.
- **July 2005:** Implementation begins.

# The Agreed Upon Evidenced Based Practices

## Multidimensional Treatment Foster Care (MTFC)

MTFC reduces “days on the run”

MODEL OVERVIEW



Two years past baseline (n=79)  
*Journal of Emotional and Behavioral Disorders, Spring 2004.*

### PROPOSAL

**IMPROVED OUTCOMES:** Increases placement stability and successful family reintegration, and reduces arrests and convictions.

**TARGET DISORDERS:** Oppositional Defiant and/or Conduct Disorder, and substance abuse.

**ELIGIBILITY:** Child/youth meets community JRA standards, CA Level 1A or 1B BRS, mental health diagnosis, or is being diverted from CA Long-term Inpatient Program (CLIP).

**AGE:** 10-18 year olds and family members.

**SETTING:** Out-of-home care with family participation during care or outpatient.

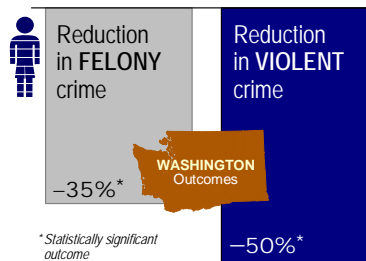
**COST:** Per Diem rates \$161 per day.

- MTFC is a cost-effective alternative to group care for adolescents with problems with chronic antisocial behavior, emotional disturbance, and delinquency.
- Community foster families are recruited and closely trained to provide adolescents with: treatment and intensive supervision at home, in school, and in the community; clear and consistent limits and follow through on consequences; positive reinforcement for appropriate behavior, a relationship with a mentoring adult, and separation from antisocial peers.
- Weekly individualized therapy and group meetings are integral components and a program monitor maintains daily contact with the foster parents.
- Biological or placement families actively participate in the treatment, learning effective parenting skills, and preparing for the child/youth's return home.
- MTFC is recommended as a cost-effective model by the Washington State Institute for Public Policy, is a Blueprint Program from the Center for the Study of Prevention of Violence, and is an Effective SAMSHA Model Program.

## Functional Family Therapy (FFT)

FFT reduces arrests

MODEL OVERVIEW



\* Statistically significant outcome

### PROPOSAL

**IMPROVED OUTCOMES:** Increases placement stability and family placement and reduces arrest and convictions.

**TARGET DISORDERS:** Oppositional Defiant and/or Conduct Disorder, Disruptive Behavior Disorder

**ELIGIBILITY:** High need multi-system child/youth, FRS Phase II, family is in conflict, low level of family engagement, long history of failure in other systems, at risk to commit crimes, and family therapy is indicated.

**AGE:** 10-18 year olds and family members

**DURATION:** Average 15 service hours (10-30)

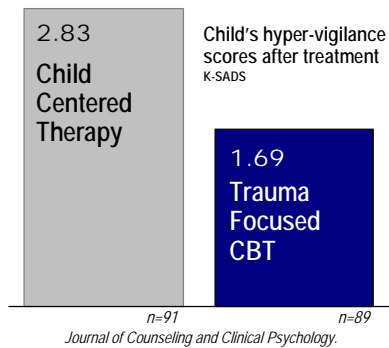
**SETTING:** In-home or out-patient with biological, adoptive, or long-term foster family and substance abuse.

**COST:** Per Diem rates \$35 per day.

- FFT is a prevention/intervention program for at-risk adolescents and their families, including a specific focus on younger siblings.
- FFT is a short-term intervention – on average 8 to 12 sessions and up to 30 hours of direct services for more complex situations. It is based on established clinical theory and practice.
- Treatment phases include youth and family engagement and motivation, behavior change, and generalization.
- Although commonly used as an intervention program, FFT is also an effective prevention program for at-risk adolescents and their families. Whether implemented as an intervention or a prevention program, FFT may include diversion, probation, alternatives to incarceration, and/or reentry programs for youth returning to the community following release from an institutional setting.
- FFT is recommended as a cost-effective model by the Washington State Institute for Public Policy and is a Blueprint Program from the Center for the Study of Prevention of Violence.

## Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

### Post Traumatic Stress Disorder Symptoms



#### PROPOSAL

**IMPROVED OUTCOMES:** Decreases Post Traumatic Stress Disorder (PTSD) symptoms in the children, and depression and anxiety in the parents.

**TARGET DISORDERS:** PTSD, depression, anxiety and behavior problems associated with trauma.

**ELIGIBILITY:** Any child or youth who has experienced trauma and is exhibiting PTSD, depression, emotional distress, behavior problems, or sexualized behaviors.

**AGE:** 3-18 year olds with family in some sessions

**DURATION:** 12 sessions in 2 months.

**SETTING:** Outpatient.

**COST:** \$240 per week.

#### MODEL OVERVIEW

- Trauma Focused CBT targets children who have experienced trauma due to sexual and physical abuse, death, and witnessing violence. Both children and their parents are involved in the therapy sessions.
- TF-CBT is an outpatient model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy.
- TF-CBT is based in established theory and practice. With TF- CBT, children and parents learn skills related to addressing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.
- TF-CBT is useful for children/youth all along the continuum of care.
- TF-CBT is recommended as a "Well Supported and Efficacious" program by the National Child Traumatic Stress Network.

## Family Integrated Transitions (FIT)

### Each dollar invested in FIT saves three



#### PROPOSAL

**IMPROVED OUTCOMES:** Reduces arrests and convictions.

**TARGET DISORDERS:** Substance abuse and/or dependence and a DSM IV Axis 1 diagnosis.

**ELIGIBILITY:** Youth with substance abuse and/or dependency disorder and Axis 1 disorder, and are scheduled to be released from either a JRA institution, Level 1A or 1B BRS placement or CLIP facility.

**AGE:** 11-17 year olds and family members.

**DURATION:** Typically 6 months.

**SETTING:** In-home and community.

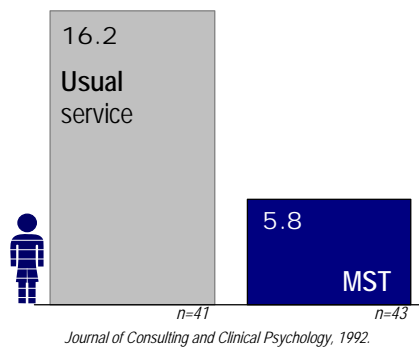
**COST:** Typical Per Diem rates \$50 per day.

#### MODEL OVERVIEW

- FIT targets youth with both mental illness and alcohol/drug problems, who are leaving a residential facility to return to community life. Both youth and their families are involved
- FIT uses an intensive home- and community-based model of service delivery beginning in a residential setting, then continuing four to six months in the community. It is an intensive outpatient model.
- FIT combines elements of four proven therapeutic approaches – MST, Motivational Enhancement Therapy, Relapse Prevention, and Dialectal Behavior Therapy – in an integrated model designed to address the unique needs of teenagers with both mental illness and chemical dependency.
- The Washington State Institute for Public Policy has found that FIT reduces felony recidivism among these youth. Therefore, the Institute recommends it as a cost-effective model.

## Multi-Systemic Therapy (MST)

MST means less time away from home



Journal of Consulting and Clinical Psychology, 1992.

### PROPOSAL

**IMPROVED OUTCOMES:** Increases family cohesion, and reduces aggressive behavior, arrests, and convictions.

**TARGET DISORDERS:** Chronic, violent, substance abusing youth.

**ELIGIBILITY:** Serious juvenile offender at high risk for out-of-home placement, youth at risk of Children's Long-term Inpatient Program or Behavior Rehabilitation Services placement.

**AGE:** 10-18 year olds and family members.

**DURATION:** Range of four months.

**SETTING:** Community based.

**COST:** Per Diem rates \$58 per day.

### MODEL OVERVIEW

- MST targets chronic, violent, or substance-abusing youth, ages 12 to 17, at high risk of out-of-home placement – and their families.
- MST uses an intensive home- and community-based model of service delivery. On average, youth and family experience 60 hours of contact over four months.
- MST works to empower both youth and parents, through support and skill building designed to:
- Equip parents with the skills and resources needed to address the problems of raising teenagers
- Help youth develop the skills needed to cope with family, peer, school, and neighborhood problems.
- MST has been proven effective with families from a range of socioeconomic and ethnic backgrounds. The impact of the program on African-American and Hispanic youth has been well-studied.
- MST is recommended as a cost-effective model by the Washington State Institute for Public Policy and is a Blueprint Program from the Center for the Study of Prevention of Violence.

## Next Steps

### Four Strategies Toward Effective Therapy Interventions

The Children's Mental Health Initiative will be implemented using the four strategies, all of which are designed to support families, children, and youth to build strong, productive relationships. Our work recognizes the role of parents and their right to make choices that benefit their child and family. We believe that the services we introduce through this effort will add valuable options for parents to consider.

### CONTACTS

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